Chapter 19

Medical Negligence

"A man may be a poor writer, a bad painter, or a bad actor but a man cannot and must not be a bad doctor." – Prof. M.P. Konchalovsky[1]

1. Concept, Elements & Rationale of Medical Negligence

In normal sense, negligence means nothing else but carelessness. In legal sense, negligence means omission by a professional to do something that a reasonable man is expected to follow when discharging professional function. Negligence is an omission to do something, which a reasonable man, guided upon those considerations that ordinarily regulate the conduct of human affairs, would do, or doing something that a prudent and reasonable man would not do.[2]

Negligence is a failure in maintenance of reasonable standard of practice or conduct. In simplified form, negligence can be understood as:

- Omitting to do something that a reasonable man would do.

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[1] Nepal Medical Council Code of Ethics & Professional Conduct for Doctors, 2017, p. 1

[2] *Bly* v. *Birmingham Waterworks Co.* (1856) 11 Exch. 781

- Doing something that a reasonable man would not do
- Causing mischief to third parties through such commission or omission.
- The mischief is not intentional.

Original understanding of negligence has got modified in modern legal practice. It began to be defined as tort involving breach of a duty by a person to take care resulting into damage to the third person. Winfield and Jolowicz define negligence as "breach of a legal duty to take care which results in damage, undesired by the defendant to the plaintiff."

Any negligence occurred through medical practitioner during the discharge of their official duty is known as medical negligence. Medical profession is related to activities of saving life of innocent patient. Medical practitioners are considered as qualified in their profession and it is presumed, they will not commit any mistake knowingly in the matter during the process of treatment of their patient.

Medical service is a kind of service in which labor, skill or knowledge is used to advise and treat disease, and hence this class of service falls under the ambit of consumer relationship and Consumer Protection law as stated in *Dr. D.B. Shah* case.[3]

Consumer Protection Act, 2075 B.S is the specific law to address grievances of medical negligence in Nepal.

Indian Supreme Court in 1996 through Indian Medical Association case[4]

brought medical negligence within the ambit of consumer Protection Act. Initially held that medical services provided by all private hospitals and health centres except government hospitals are "contract for service" and fall within the ambit of Consumer Protection Act. But these days negligence committed at government hospitals are also equally held accountable and vicarious liability is imposed on government for negligence committed by its employee doctors in government hospitals.

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[3] *Dr. Dinesh Bikram Shah v. Pro Public* NKP 2066, V 11, D.N. 8262

[4] *Indian Medical Association* v. *V.P. Shantha and Others* AIR 1996, SC 550

Judiciary in Nepal has yet to clearly interpret vicarious liability of government over negligence committed/omitted in government hospitals or by government doctors. State's attempt to disengage itself from liability on the ground that it was a case of negligence of the doctor did not find acceptance with the court in India after the court in *Panjab State* case[5] found state vicariously liable and left it to the state to initiate departmental action to fix liability on erring doctors. The state that ran the hospital was held vicariously liable in *R. P. Sharma* case[6] for death of a patient caused due to the negligence of the hospital staff by transfusion of wrong blood group. In *Jan Sangharsh Manch* case,[7] State has been directed to pay IRs. 50,000/- for medical negligence in government hospital due to transfusion of wrong blood (group) resulting in death. Vicarious liability of the state government was affirmed in *Kanchanmala Vijaysing Shirke* case,[8] where a clerk had driven the jeep in place of the driver resulting in the death of a scooterist.

If a person claim oneself as possessing special skill and knowledge by or on behalf of a patient, the person owes duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes treatment and the patient submits to his direction and treatment, accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment.[9] Thus, medical practitioners are under legal duty to treat with diligence their patient and failure of which results into medical negligence. Medical negligence has following constituent elements:

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[5] *Panjab State* v. *Surinder Kaur*, 2001 ACJ 1266.

[6] *R. P. Sharma* v. *State of Rajasthan*, AIR 2002 Raj 104.

[7] *Jan Sangharsh Manch* v. *State of Gujrat*, 2000 ACJ 1523.

[8] *State of Maharashtra* v. *Kanchanmala Vijaysing Shirke*, (1995) 5 SCC 659.

a) A medical practitioner is under *duty to take care* his patient.

b) The medical practitioner has *breached his duty* to care.

c) The patient victim has to suffer *damage or loss* due to breach of duty to take care. Such loss could be physical, mental or financial.

d) There is causative link between negligent conduct and damage suffered by victim.

There is a general principle of medical negligent that a medical practitioner does not have mala fide conduct or commit negligence to their patient. If anyone accuses of medical negligence to the medical practitioner, the burden of proof lies on the accusing party.[10]

The concept, rationality and philosophy behind emergence of liability for medical professionals in case of negligent practice is founded on the 'Principle of Professionalism'. Courts require that the professionals should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. Profession differs from occupation. While expressing his reluctance to propound a comprehensive definition of a 'profession', Scrutton L.J has said:

> *Profession in the present use of language involves the idea of an occupation requiring either purely intellectual skill, or of manual skill controlled, as in painting and sculpture, or surgery, by the intellectual skill of the operator, as distinguished from an occupation which is substantially the production or sale of*

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[9] *R* v. *Beteman* (1925)

[10] Supra note 3.

commodities. The line of demarcation may vary from time to time. The word 'profession' is used to be confined to the three learned professions, the Church, Medicine and Law. It has now I think a wider meaning.[11]

According to Rupert M. Jackson and John L. Powell, the occupation which is regarded as professions has four characteristics:

a) The nature of the work which is skilled and specialized and a substantial part is mental rather than manual.

b) Commitment to moral principles which go beyond the general duty of honesty and a wider duty to community which may transcend the duty to a particular client or patient.

c) Professional association which regulates admission and seeks to uphold the standards of the profession through professional codes on matters of conduct and ethics; and

d) High status in the community.

During the 20th century, an increasing number of occupations have been seeking and achieving 'professional' status and that this has led inevitably to some blurring of the features which traditionally distinguish the professionals from other occupations. In the context of the law relating to professional negligence, authors have accorded professional status to seven specific occupations, namely, (i) architects, engineers and quantity surveyors, (ii) surveyors, (iii) accountants, (iv) solicitors (They usually perform the majority of their legal work in a law firm or office setting), (v) barristers (advocates representing clients in court), (vi) medical practitioners and (vii) insurance brokers [12] Whatever be the profession, in devising a rational approach to professional liability, which must provide proper protection to the consumer, the approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties.[13]

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[11] *IRC* v. *Maxse,* (1919) 1 KB 647: 88 LJ KB 752.

[12] Jackson & Powell, *Professional Negligence,* (3rd edn.) paras 1-01 and 1-03.

Nepalese law recognizes health as "service" and not as business.[14] Our law also defines- emergency health service, basis health service, and health service.[15] Medicine is respectfully called noble profession because of its primary aim to serve humanity rather than to pocket filling. Medical profession is a service and not business. Every patient sees a medical practitioner as more than a human being. Medical service has experienced conversion into business and the behavior of medical practitioner has been changing. This has continuously derogating the faith of public over medical service. Thus, proper implementation of laws relating to medical practice, ensuring standard forms of conduct, and addressing instances of medical negligence are important to maintain order in medical service.

2. Medical Negligence versus Medical Malpractice

Medical negligence involves failure to maintain reasonable standard of care to patient during diagnosis and treatment. It is the breach of duty against the patient and the patient would be suffered from the physical, mental or economic damage. Mostly direct effect is limited to the patient. For example- denying to admit emergency patient brought into the gate of hospital is medical negligence of the hospital administration, doctors, and

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[13] Sura Sumalatha, "Negligence in Medical Profession and its Impact", 4 *Supreme Court Journal* 49 at 52 (2012).

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nurses if the patient dies from such denial. Even if the hospital does not have required adequate medical facilities to treat such emergency patient, it is the duty of hospital to provide needy first aid (example oxygen gas, stopping blood loss, giving temperature etc.) and make arrangements towards sending the patient to needed higher health facility hospital without wasting time. In case the patient dies of roaming from one hospital to another just because of denial of all hospitals to treat or admit such emergency patient, it is the joint liability of all hospitals for medical negligence in case of death of such patient. This phenomenon is usual and frequent occurring misfortune in Nepal health care system but no law exist till date to bring such health institutions and medical professionals accountable for such negligence and inaction. What exactly is medical negligence for the purpose of law has been published in an article[16]by author in Kantipur daily newspaper for drawing attention of concerned policy makers.

Numerous causes exist behind occurrence of medical negligence at the level of doctor/paramedical staff/hospital authorities in Nepal. They include errors in surgical treatment, errors in diagnosis, professing/holding out/performing beyond level of competence by doctor/hospital, failure to attend/treat emergency patient in time, and failure of advice and communication. Research [17] conducted by the author in Nepalese context reflects- 'Error in surgical treatment' is the major cause behind medical negligence as it covers 33.33% of total medical negligence compensation complaints. Second major cause of negligence includes 'errors in diagnosis' which constitutes 22.22% of the total medical negligence compensation claims. Other three causes that fall under third major causes of medical negligence include 'professing/holding out/performing beyond level of competence by doctor/hospital', 'failure to attend/treat emergency patient in time,' and 'failure of advice and communication' of total negligence claims each occupying 14.28% of total negligence claims. Hospitals/nursing homes/clinics, who provide medical service through agents (doctors and nurses), the cause of corporate negligence is 'vicarious liability' and it is interesting to note that these health institutions have been vicariously liable for negligence in 71.42% cases. Likewise, negligent sale of drugs by a pharmacy employee has become a cause of vicarious liability of pharmacists in 7.14% cases in Nepal.

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[16] Dr. Ramesh Parajuli; *Chikitsakiya Laparbahi K lai Mannee?*, Kantipur Daily National Newspaper (5 Oct. 2017) (Retrieved on 6 Nov. 2020: https://ekantipur.com/opinion/2017/10/05/20171005071923.html)

[17] Ramesh Parajuli; Medical Negligence in Nepal: A Critical Study of Law and Practice in the Light of Indian Experiences (2013). Unpublished. (Doctorate research carried under the guidance of Prof. Dr Tahir Mahmood and co-guidance of Associate Prof. Dr. Kiran Gupta from Amity Institute of Advanced Legal Studies,

Medical malpractice has wider impact to society than medical negligence even though, medical malpractice may be a cause of medical negligence. Any activity that erodes and degrades the dignity of noble medical profession or any act that is not expected from ethical medical professional in course of professional responsibility is known as medical malpractice. Medical malpractice adversely affects public at large. Medical malpractice committed by doctor, nurse, hospital, pathological clinic, pharmacy, pharmaceuticals, medical equipment manufactures etc. have detriment effect in medical service. A minor medical malpractice may cause damage to public at large and huge financial burden in the name of health treatment. Some examples of medical malpractice are:

- Over prescription of drugs with motive of commission.
- Prescription of unnecessary drugs for pocket filling.
- Purchasing damaged or sub-standard medical equipment showing price of high standard.

- Prescription of medicine by person not qualified as medical practitioner.
- Prescribing drugs with trade name instead of generic name.
- Establishment and operation of pharmacy without authority of regulatory body.
- Practice of referring patient to particular pharmacy or lab.
- Government hospital doctors pressuring or influencing patients to visit their clinics for the treatment that could be possible even in hospital.
- Charging higher rate for service than that prescribed lawfully.
- Surgical errors.
- Establishment of hospital or diagnosis centre without fulfilling standard requirement.
- Misguiding patient's family members regarding the condition of patient.
- Recommendation of unnecessary surgery in minor petty case.
- Withholding already dead patient by hospital ICU for many days without letting patient's family know and meet the dead patient just with motive to impose extraction of more money in the name of hospital charge per day.
- Trying to conceal evidences that might establish medical negligence.
- Altering the contents of patient treatment file documents with motive to escape liability for negligent practice.

Above discussed are the more frequent examples of medical malpractice. Medical malpractice is intentional in nature. Medically related professionals commit malpractice with intent to creating more profit and pocket filling.

Both medical negligence and medical malpractice seem similar to a layman, but they are completely different for a lawyer. The major differences between medical negligence and medical malpractice can be presented in tabulated form as follows:

Differences	Medical negligence	Medical malpractice
Concept	Duty-breach-damage	Unethical or criminal practices degrading nobleness of medical profession
Impact	Limited to immediate patient victim and family	Broader impact to society. Injures health care system.
Effect	Physical, mental or financial loss to patient	Reduces public trust on medical professionals and system
Nature	Commission or omission	Commission (unethical practice)
Intention	Lack of intention. Only negligence	Intentional act with motive of pocket filling (or gaining undue benefit or profit)
Liability	Usually civil liability (by contract or tort). Rarely criminal liability.	Criminal liability either fine or punishment or both
Remedy	Usually compensation	Disciplinary action, fine, even imprisonment
Existing laws	Mainly, Consumer Protection Act, 2018 (for compensation/civil negligence) Rarely, Section 232 of *Muluki* Criminal Code, 2074 B.S. (for criminal negligence)	No special and specific law to address medical malpractices. Scattered. Few aspects covered by Rule 22 of Nepal Medical Council Regulation, 2024 B.S and Public Health Service Act, 2075 B.S.

Locus-standi	Victim consumer or consumer organization or relatives of handicapped/deceased victim.	Usually open *locus standi* as it is subject of public interest litigation. (Eg. Section 36 CPA- broad sectoral malpractices)
Who commits?	Generally, doctor, hospital or person or body directly connected to treat.	Many actors of ranging from producer of medical equipment to retailers, hospital to small clinic.

A same act could be medical negligence or medical malpractice depending upon mental element of the wrongdoer. For example, a pharmacist selling date-expired drug to patient without bothering to verify/look at the expiry date of the drug is committing medical negligence. Pharmacist here is liable to compensate patient party under civil liability. The same pharmacist if sells the date-expired intentionally or having knowledge that the drug's date has already expired with motive of saving his business investment from going into loss, it is medical malpractice to be addressed under criminal liability and punishable with imprisonment or and fine.

Medical malpractice is not just threat to human life but it injures wider community. Health service no longer remains service, it becomes business if malpractices are not controlled. Increase in medical malpractices makes public health service unaffordable and inaccessible. People will be compelled to spend more money to maintain their health standard. Malpractice by doctors such as not providing adequate counseling to patient, causing repeated examination through referral to lab having their investment, surgery without full examination, instant administration of antibiotic are recognized by the supreme court of Nepal.[18] Both medical negligence and medical malpractice need to be prevented to maintain healthy medical profession.

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[18] *Prof. Dr. Bulanda Thapa v. Shushma Thapa 2074,* D.N. 9814

It will be misfortune if health care system is politicized. Politicians should either do politics or business. They should not do both as this will create conflict of interest at the cost of public welfare. Law needs to be enacted to prohibit politicians from allowing to do business and invest shares in private medical colleges, hospitals and nursing homes. Only then can Government effectively take action against those private health care institutions, hospitals, medical colleges, and private health care companies that are complained of nurturing and nourishing medical malpractices and so called medical mafia. Politics is a backbone of all sectors including health care system. I disagree with those who say- politics is a dirty game. For me- politics is a beautiful game, players may be dirty. We ourselves are fortune makers of this country, we ourselves have duty to purify our political system.

For making *samriddha Nepal*, author has a dream and I would propose- State treasury should bear livelihood cost and basic allowance of all politicians and make them focused only on policy making. Who can join politics (*samaj sewa*), what are the qualifications for getting license to enter politics so that public can trust these people will certainly contribute in making healthy nation. Who will provide license? At what age politicians must get compulsory retirement so that they can relax in old age and focus on own health rather than taking stress of nation's health etc. needs to be determined by law. Establishment of separate Faculty in University that teaches politics and produces politician manpower needed for the country is advisable. The Faculty should make arrangements for inviting influential politicians and Statesman periodically as guest lecturers to discuss with young energetic student politicians, the pros and cons they experienced and the errors or mistakes they committed negligently, unknowingly during their political life. The Faculty will nurture student politicians with required ethical values, vision, spirit, motivation, techniques of nation building and pass out them as role model politicians equipped with requisite theoretical and practical political expertise. We cannot expect healthy nation until our politics is healthy, fair, transparent, and ethical and until all citizens are healthy. Non-commercialized, non-politicized, and non-commissionalized health care system is a prerequisite for healthy and prosperous nation.

3. Tests to determine Medical Negligence

Prior to determining whether medical negligence has happened in any questioned case, courts worldwide have been relying on two major tests- Bolam Test[19] and Bolitho Test.[20]

In 1954, John Hector *Bolam* underwent electroconvulsive therapy (ECT) for clinical depression during which medical opinion differed on how best to minimize the risk of injuries possible from convulsions induced by ECT. In Mr Bolam's case, the technique of manual restraint was ineffective and as a result he fractured his pelvis. He subsequently argued that the doctor had been in breach of the standard of care in providing treatment, and that the hospital had been negligent. The *locus classicus* of the test for the standard of care in law, required of a doctor, developed from this landmark case. Justice McNair, in his direction to the jury, said:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art...Putting it the other way round, a man is not negligent, merely because there is a body of opinion who would take a contrary view.[21]

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[19] *J. Bolam* v. *Friern Hospital Management Committee*, All ER 118 (1957).

[20] *Bolitho v. City and Hackney Health Authority*, (1994) 4 All ER 771 (HL).

[21] *Ibid.*

It connotes that if a medical practice is supported by a responsible body of peers, then the *Bolam* test is satisfied and the practitioner has met the required standard of care in law. This test has been applied on a numerous occasions in cases of medical litigation. In the important Scottish case of *Hunter* v. *Hanley*,[22] there was a clear endorsement of the custom test in Lord Clyde's dictum:

> To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.

The Indian Courts applied this test as early as in *Dr. Lakshman Balkrishna* case.[23] In this case, the duties which doctor owes to his patient came up for consideration. The Court held that the practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires. However, the doctor has discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of emergency.

In Achutrao's case,[24] a mop was left inside the lady patient's abdomen during an operation. Peritonitis developed which led to a second surgery being performed on her, but she could not survive. Liability for negligence was fastened on the surgeon because no valid explanation was forthcoming for the mop having been left inside the abdomen of the lady. In *Laxman Balkrishna Joshi* case,[25] death of the patient was caused due to shock resulting from reduction of the fracture attempted by the doctor without taking the elementary precaution of giving anaesthesia to the patient. The doctor was held guilty of negligence and liable to pay damages. In *Dr. P.N. Rao* case,[26] a very promising young boy of 17 was admitted in a government hospital for removal of tonsils. As a result of the negligence in the administration of anaesthesia during the operation, the patient became victim of cerebral anoxia making him dependant on his parents. The anesthetist, the surgeon and the government were all held liable for damages to the plaintiff.

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[22] B Hurwitz, *Clinical Guidelines and the Law* (1995) 311 BMJ 1517.

[23] *Laxman Balkrishna Joshi* v. *Trimbak Babu Godbole*, AIR 1969 SC 128.

[24] *Achutrao, Haribhau Khodwa v. State of Maharashtra*, (1996)2 SCC 634.

In *Smt. Bholi Devi* Case,[27] when an injection meant for intramuscular use was administered as an injection intravenous in a government hospital resulting in death of the patient, the government was held liable in public law for damages under Article 226 of the constitution. In *Nizam's Institute of Medical Sciences* case,[28] the complainant who was then an engineering student suffered from recurring fever. The X ray examination revealed a tumour in left hemithorax with erosion of ribs and vertebra. Even then without having MRI or Myelography done, cardiothoracic surgeon excised the tumour and found vertebral body eroded. Operation resulted in acute paraplegia of the complainant. MRI or Myelography at the pre-operation stage would have shown necessity of a neurosurgeon at the time of operation and the paraplegia perhaps avoided. Consent was not taken for removal of tumour but only for excision biopsy. The hospital and the surgeon were held liable for negligence. In *Smt Santra* case,[29] also *Bolam*'s test has been approved. In *Jacob Mathew* Case[30], Indian Supreme Court heavily relied on the case of *Bolam*. The court referred to the opinion of McNair, J. defining negligence as under:-

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[25] *Supra* note 22.the 560

[26] *Dr. P.N. Rao* v. *G. Jayaprakasu*, AIR 1990 AP 207.

[27] *Smt. Bholi Devi* v. *State of Jammu & Kashmir*, AIR 2002 SC 65.

[28] *Nizam's Institute of Medical Sciences* v. *Prasanth S. Dhananka* [2009] 6 SCC 1.

> Where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill ... The test is the standard of the ordinary skilled man exercising and professing to have that special skill ... *A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.* [Emphasis added]

In the decision of *INS Malhotra (Ms)* case,[31] it was held that negligence in the context of the medical profession that a simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional as long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed.

Criticisms of the Bolam Test

The principal criticism of the *Bolam* test is that it fails to draw a distinction between 'what is done' and 'what ought to be done'. Whether an action is negligent or not should be judged against a standard of what ought to be done.[32] Something which if done even if by most people, could still be negligent if it falls below the standard of what ought to be done. The *Bolam* test is seen as stating the standard of care as dependent upon what is done, thereby allowing medical practitioners to set for themselves the legal standard by eliciting the support of a 'reasonable body of medical men'. Should this be allowed in medicine when this is not the case in other areas of professional liability, where the expected standard of the defendant is a matter that is set by the court?[33]

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[29] *State of Haryana and Ors.* v. *Smt Santra* (2000) 5 SCC 182.
[30] *Jacob Mathew* v. *State of* Punjab [2005] 6 SCC 1.
[31] *INS Malhotra (Ms)* v. *Dr. A. Kriplani* (2009) 4 SCC 705.

The *Bolam* test has been justifiably applied to cases of medical litigation involving diagnosis [34] and treatment. [35] However, this is not the correct test for information disclosure to patients, or for all matters pertaining to medical intervention in persons unable to give valid consent. These are issues involving ethics and the fundamental rights of individuals. Critics have agreed that the court should set the standard in such cases, rather than a body of medical opinion, no matter how responsible or authoritative.[36]

In *Sidaway* case, [37] a case concerning the level of information that should have been disclosed to a patient, the speech of Lord Bridge in the House of Lords is particularly apposite:

Whether non disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test. This approach has been criticised as being excessively deferential to medical opinion when balanced against the rights of a person to be informed about the risks and benefits of medical intervention. The doctrine of consent has now evolved in favour of warning the patient of all material risks inherent in the proposed treatment.[38] In modern medical practice, obtaining consent requires not only giving patient information, but also ensuring that the patient gives consent with understanding.[39]

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[32] A. Montrose, *Is Negligence An Ethical or Sociological Concept?* 21 Med LR 259-96 (1958).

[33] *Edward Wong Finance Co Ltd.* v. *Johnson, Stokes & Masters* [1984] AC 296.

[34] *Maynard* v. *West Midlands Health Authority* [1985] 1 All ER 635.

[35] *Whitehouse* v. *Jordan* [1981] 1 All ER 267.

[36] H. Teff, *The Standard of Care in Medical Negligence – Moving on From Bolam*, 18 Oxford JLS 473-84 (1998).

[37] *Sidaway* v. *Board of Governers of the Bethlem Royal Hospital* [1985] 1 All ER 643.

The *Bolam* principle has also been applied to the ethical issues inherent in medical interventions performed on mentally incapacitated patients unable to give valid consent. In *Re F*,[40]

the question that arose was whether sterilisation should be performed in a 36 year old patient who had a mental age of five. A body of medical opinion supported this as being in the 'best interests' of the patient. In an ethical matter such as this, should it not be the court that decides what is in the patient's best interests? However, in *Re F*, the decision was left to medical professionals:

> A doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting ... provided that the operation or other treatment concerned is in the best interests of such patients.

The *Bolam* test would appear to have crossed the boundaries of diagnosis and treatment, as well as the limits of medicine, thereby enlarging the role of the doctor to that of a moral arbiter.[41] It is unlikely that in *Bolam* the judge meant that compliance with a body of medical practice was conclusive in terms of escaping liability for negligence. In his summing up, he stated:

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[38] P. Marks, *The Evolution of the Doctrine of Consent,* 3 Clin Med 45-47 (2003).

[39] M.K. Mayberry and J.F. Mayberry, *Consent with understanding: A Movement Towards Informed Consent,* 2 Clin Med 523-6 (2002).

[40] *F* v. *West Berkshire Health Authority* [1989] 2 All ER 545; [1990] 2 AC 1.

> The result of the evidence is that you are satisfied that his practice is better than the practice spoken of on the other side, then it is really the stronger case.[42]

This seems to leave open the possibility of the court having a more active role in setting the standard of care by objectively evaluating the practice prefered by each of the parties.

Bolitho[43]: The Dawn of A New Era

The central legal issue for House of Lords in Bolitho, a clinical negligence case was whether or not non- intervention by a doctor caused the plaintiff's injury. The facts of the case were that Patrick Bolitho, a two year old child, suffering catastrophic brain damage as a result of cardiac arrest due to respiratory failure. The senior pediatric registrar did not attend the child, as she ascribed to a school of thought that medical intervention, under those particular circumstances, would have made no difference to the end result. Liability was denied on the grounds that even if she had attended, she would not have done anything that would have materially affected the outcome. This view was supported by an impressive and responsible body of medical opinion. In giving judgment, Lord Browne-Wilkinson said:

> The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before

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[41] *Whitehouse* v. *Jordan* [1981] 1 All ER 267.

[42] *Supra* note 19.

[43] *Bolitho v. City and Hackney Health Authority*, (1994) 4 All ER 771 (HL).

accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.[44]

Here is an explicit assertion from the highest judicature in the land that the court may want to look beyond *Bolam* and actively assess the calibre and merit of the basis on which the standard is proclaimed. The key manner by which the judgment in *Bolitho* might impact upon the principle in *Bolam* is that the court is likely to take much more interventionist stand in appraising the professed standard of care. In practical terms, the first stage would be for the court to assess whether the decision had responsible peer support based on an approach that was structured, reasoned and defensible. The professed opinion must withstand 'logical analysis'. This broadly reflects the *Bolam* test as it is known. The second stage, and this is where Bolitho might really take effect, is to assess on a 'risk analysis' basis the validity of accepting the treatment or course of action offered by the defendant and more importantly, the validity of rejecting competing decisions. In undertaking such an analysis, the court may look at a number of factors, including the magnitude of the risk, the comparative risks of alternative interventions and treatments, the seriousness of the consequences, the ease by which the risk might be avoided, and the implications of such avoidance in terms of finances and resources of health care.

Bolitho Applied

In determining the legal standard of care, the court has shown a definite movement towards applying the principle

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[44] *Ibid.*

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enumerated in *Bolitho* in recent cases. In *Penne,*[45] three women developed cervical cancer, although cyto-screeners had previously reported their cervical smears as being negative. In preferring the evidence provided by experts for the plantiff, the judge said he did not consider the evidence provided by the defendant experts as standing up to logical analysis because:

> There were admitter abnormalities which, to put it most favourably to the cyto-screener, he could not positively have said they were no pre-cancerous ... [Having] regard to the potentially disastrous consequences of a mistaken identification, a reasonably competent cyto-screener would have classified the smear as borderline.

This decision was upheld in the Court of Appeal and, in giving judgment, Lord Woolf said:

> In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity.[46]

This demonstrates that a coherent and reasoned opinion of a suitably qualified expert will be weighed and considered against a coherent reasoned rebuttal. By comparing the evidence in such a way, the court would determine what is the appropriate standard of care, using a 'logical analysis' approach.

Marriot[47] further demonstrates how the Court of Appeal took a 'risk analysis' approach in determining the legal standard. In this case, the plaintiff suffered head injuries after a fall and was taken to hospital for investigations, and discharged the next day. At home his condition worsened. The plaintiff suffered an intracranial bleed which finally led to residual paralysis and a speech disorder. The defendant's experts argued that the decision to leave the plaintiff at home could be supported on the grounds that the risk of an intracranial lesion was very small. The trial judge, finding for the plaintiff, said that although the risk was very small, the consequences of things going wrong are disastrous to the patient. In such circumstances, the only reasonably prudent course would be to readmit for further testing and observation.[48] The judge added that readmission of the patient would have been particularly appropriate as facilities for further investigation were relatively easily available. The court of appeal approved of this decision on the basis of an appropriate judicial exercise in determining the required standard of care by using the 'risk analysis' approach of *Bolitho.*

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[45] *Penney, Palmer and Canon* v. *East Kent Health Authority* [2000] Lloyds Rep Med 41.

[46] *Ibid.*

[47] *Marriott* v. *West Midlands Health Authority* [1999] Llyods Rep Med 23.

In *Pearce,*[49] the issue before the court was whether or not a doctor ought to have informed a pregnant woman at 42 weeks of gestation of the additional risk of stillbirth which was inherent in allowing the pregnancy to continue, thus enabling her to make a fully informed choice. Lord Woolf, in Court of Appeal, said:

> If there is a significant risk which would affect the judgment of a reasonable patient, then in the normal case it is the responsibility of the doctor to inform that patient of that significant risk, if the information is needed so that the patient can determine for himself or herself as to the course he or she should adopt... the doctor in determining what to tell a patient, has to take into account all the relevant considerations, which

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[48] *Ibid.*

[49] *Pearce* v. *United Bristol Healthcare NHS Trust* [1998] 48 BMLR 118.

include the ability of the patient to comprehend what he has to say to him or her.[50]

This pronouncement reinforces the contention that peer approval of medical practice alone would not be sufficient to satisfy the standard in law. In fact, the *Bolam* case in common laws jurisdiction is weakened in recent years by reasons of series of decisions in Australia, Canada, United States, United Kingdom and even in India to some extent. In Nepal however, judiciary has still not yet encountered with any cases of medical negligence where necessity to go beyond *Bolam* test has been felt even if evidence law[51] allows ample space for courts to frame their own opinion by declaring expert opinion persuasive in nature.

In *Malay Kumar Ganguly* Case,[52] The Indian Supreme Court has made a reference to the test laid down by the Bolitho's case. It was observed:

The court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

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[50] *Ibid.*

[51] Section 18 of Evidence Act, 1977 says: "The fact expressed by a person in the document prepared in the course of inquiry or examination of any act, incident or situation/ condition pursuant to the prevailing law, *may be taken as evidence*, in case he/she appears before the court and records his/her statement as an witness." [Emphasis added]

[52] *Malay Kumar Ganguly* v. *Sukumar Mukherjee*, AIR 2010 SC 1162.

In *V. Kisan Rao* Case,[53] the Indian Supreme Court has made a reference to Bolitho's case where it was observed:

> Even though *Bolam* test has not been uprooted it has come under some criticism ... there is an argument to the effect that *Bolam* test is inconsistent with the right to life unless the domestic courts construe that the requirement to take reasonable care is equivalent with the requirement of making adequate provision for medical care. In the context of such jurisprudential thinking in England, time has come for this Court also to reconsider the parameters set down in *Bolam* test as a guide to decide cases on medical negligence andespecially in view of Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care...

The judgment in Bolitho, however, suggests a judicial move at the highest level to shift the balance from an excessive reliance on medical testimony supporting a defendant doctor, to a more enquiring approach to be taken by the court. In order to reach its own conclusion on the reasonableness of clinical conduct, the court will arbitrate on the standard in each case. This would operate within the framework of normative values held by society.

Thus, patient empowerment is a strong theme in the new health service. This is likely to act as a combined force in shifting the traditional 'accepted practice' approach to one whereby the standard of care is set by the court, on the basis of 'expected practice'. This would be determined by evaluating the reasonableness of competing options.

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[53] *V. Kisan Rao* v. *Nikhil Super Speciality Hospital* (2010) 5 SCC 513.

In Halsbury's Laws of England the degree of skill and care required by a medical practitioner is stated as follows:

> The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each cases, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men. Deviation from normal practices is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care.

A doctor is not guilty of negligence if he acts in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular task. The law only condemns him when he falls short of the accepted standards of that great profession. A doctor is required to exercise a reasonable degree of care. Reasonable degree of care is that degree of care and competence which "an ordinary member of the profession who professes to have those skills would exercise in the circumstances in question." The doctor has a discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of emergency. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires. There is however, a difference between standard of care on the one hand and degree of care on the other. In the case of a doctor, the standard of care expected of him remains the same in all cases, but the degree of care will differ in different circumstances. Thus, while the same standard of care is expected from a generalist and a specialist, the degree of care would be different. A higher degree of skill is expected from a specialist when compared to that of a generalist.

generalist.

In *Vinitha Ashok* Case,[54] removal of pregnancy was done without ultrasonography and uterus of the patient had to be removed. There was expert evidence to indicate that ultrasonography would not have established ectopic pregnancy but some text books indicated otherwise. The general practice in the area in which the doctor practiced was not to have ultrasonography done. Therefore no negligence was attributed on this ground even if two views could be possible. In *Dr. P.N. Rao* Case[55]

a very promising young boy of 17 was admitted in a government hospital for removal of tonsils. As a result of the negligence in the administration of anaesthesia during the operation, the patient became victim of cerebral anoxia making him dependant on his parents. The anaesthetist, the surgeon and the government were all held liable for damages to the plaintiff. Thus, a doctor who is charged with negligence can absolve himself from liability if he can prove that he acted in accordance with the general and approved practice. He will be held liable only if the judgment is so palpably wrong as to imply an absence of reasonable skill and care on his part.

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[54] *Vinitha Ashok* v. *Lakshmi Hospital* AIR 2001 SC 3914.

[55] *Supra* note 25.

Supreme Court in *Dr. DB Shah* case[56] and Court of appeal in *Dr. G. P. Khanal* Case[57] have clearly pointed out the necessity of reasonable standard of care on the part of doctor while providing medical service. The classical statement of law in *Bolam* case has been widely accepted as decisive of the standard of care required both of professional man generally and medical practitioners in particular and holds good in its application both in Nepal and India. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. The water of *Bolam* test has ever since flown and passed under several bridges, having been cited and dealt with in several judicial pronouncements, one after the other and has continued to be well received by every shore it has touched as neat, clean and a well-condensed one.

a) Informed Consent

Informed consent is more than simply getting a patient to sign a written consent form. It requires clear communication between physician and his patient that empowers or confers ability on patient or his relative to understand and agree with free consent to undergo a specific medical intervention after being well informed with the relative risks and benefits of the treatment, alternative methods of treatment and side effects of the medication. General Medical Council UK in its guidance to doctors has clearly mentioned that the right of patients to be fully involved in decisions about their care:

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[56] *Supra* note 3.

[57] *Dr. Gopal Prashad Khanal* v. *Neshar Ahmad,* AC Butwal, DB, Compensation, DN: 289, DD: 2009/6/22.

Whenever possible, you must be satisfied, before you provide treatment or investigate a patient's condition, that the patient has understood what is proposed and why, any significant risk or side effects associated with it and has given consent.

It is to be remembered that 'consent' and 'informed consent' are two different things. Neither Ministry of Health nor Nepal Medical Council has yet issued any of such guidelines regarding informed consent. Prior to precedent laid down by Supreme Court in landmark *Dr D.B. Shah* case[58], law[59] required that consent had to be obtained for treatment or operation by certified physician and in case there is no one to give consent and if the certified physician felt that it was for the benefit of the patient, he or she can proceed without consent. This was a mere consent considered just as a formality. However, after the judgment, such consent ought to be informed and the medical profession in Nepal is now required to be guided completely by Theory of Informed Consent since 15th November 2009. The judgment says:

> *Every person is the owner of his/her own body and only the patient has right to decide which mode of treatment to undergo in his body. A doctor has to inform every details* (what has happened to patient? Which disease is it? What treatment should be done? What happens if treatment is done? What happens if treatment is not done? etc.) about disease to the

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[58] *Supra* note 3.

[59] No 2 of the then Chapter on Treatment in Country Code, 1963: In cases where a surgery has to be performed to split, burst, take out or cut *(Chirna, Forna, Jhikna, Katna)* from the body for the best interest of the patient, the medical practitioner or a *Vadihaya* holding a certificate *(Passwala)* may himself or herself perform such an operation upon receiving the consent of the patient if he or she is major and conscious and upon receiving the consent of the guardian if the patient is minor or in a state of unconsciousness, and even without receiving any consent but in the best interest of the patient on behalf of the hospital in the case of a person without any guardian.

> patient and take patients' consent prior to starting treatment *then only doctors cannot be made accountable afterwards.* This informed Consent Theory replaced Professional Standard of Care Theory after 1960s and it makes doctors more accountable towards patients while simultaneously allows patient with opportunity to be aware/informed what is happening with him/her ... *From today onwards, the medical treatment in Nepal should be guided on Theory of Informed Consent* and any cases ongoing in courts till today shall not be required to be guided by this Theory of Informed Consent ... *a directive order is hereby issued to Nepal Government, Ministry of Health to enact a Comprehensive Self Contained Medical Negligence Act guided by Theory of Informed Consent* containing issues including but not limited to: a) Limitation, b) Causation and Clinic's liability, c) Doctor patient relationship, d) Right to health and medical treatment ... Government is directed to *constitute an Expert Committee mandated to study and give back opinion to government regarding Informed Consent System of treatment practiced worldwide along with recommendations regarding what need to be done to develop it in our system* ... Such Committee should comprise of concerned doctor of Health Ministry, doctor of a government hospital, doctor of a private hospital, doctor representative of a Nepal based foreign mission hospital, doctor representative of a NMC. The Committee is required to be constituted within 3 months of obtaining a copy of this verdict and the advice of Committee ought to be implemented by Nepal government through classification of hospitals progressively within 2 years.[60] [Emphasis added]

The beauty of this judgment lies in its motto to prevent patients from being suffered and victimized by unethical medical practices that occur beyond patient's knowledge by making a transparent doctor patient relationship through the adoption of informed consent system. Side by side, it emphasizes that physicians should also be directed about their duties and rights. The judgment however is still awaiting implementation.

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[60] *Supra* note 3.

Consent in the context of a doctor-patient relationship should be expressed except where the consent can be clearly and obviously implied.[61] Going beyond the area of consent has also been held as negligence by Court of Appeal in *Khadga Kumari* Case[62] on the part of doctor and hospital management on ground of failure to take prior consent of patient or family members and consequent death of patient during second surgery after first surgery went unsuccessful.

Liability of doctor for lack of informed consent

A doctor attracts liability for negligence if he fails to obtain informed consent of a patient. The courts in some of the western jurisdictions have recognized a duty of disclosure under the following circumstances:

(i) *Disclosure regarding diagnosis*: A doctor is under a legal obligation to disclose the diagnosis. A drastic condition warrants a drastic procedure. Accordingly, a patient must be informed of the condition to enable him to decide whether to undergo the treatment or not, failing which a doctor invites liability. In *Wall* case,[63] a women had a cyst on her neck. It was deeper than what the doctor thought to be, necessitating a drastic procedure. But the doctor failed to disclose the same. The patient sustained nerve injury as a result of the procedure. The doctor was held guilty of negligence for failing to disclose the diagnosis, which would have enabled the patient to arrive at a rational decision as to whether to opt out from the procedure or not.

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[61] *Nizam's Institute of Medical Sciences* v. *Prasanth S. Dhananka* [2009] 6 SCC 1.

[62] *Khadga Kumari Kandel v. KMC Teaching Hospital*, DCC Kathmandu, CD: 2006/2/22, DD: 2009/06/11.

[63] *Wall* v. *Brim*, 138 F.2d 478, CCA 5, 1943.

(ii) *Disclosure regarding alternative methods of treatment:* The plurality of medicine paved the way for different alternative modes of treatment for a particular condition. The doctor should disclose the alternative methods of treatment along with their relative benefits and risks. In *Jefferies* case,[64] a patient underwent a retropublic prostatectomy. He became incontinent as a result of the procedure. There were four alternative modes of treatment which were not disclosed to him. He sued the doctor for his lapse to inform the alternative method of treatment. Recording a verdict in favour of the patient, the court observed:

> Where a physician or surgeon can ascertain in advance of operation alternative situations ... a patient should be told of the alternative possibilities and given a chance to decide what should be done before the doctor proceeds with the operation. The rule preserves the patient's dignity in choosing his own course.[65]

It is obvious from the above observation that if there is sufficient time before the operation, a doctor must disclose the alternative methods of treatment. If he is not aware of it, he must ascertain. He cannot plead ignorance. In *Morrison* case,[66] a woman consulted a doctor for an illness which he correctly diagnosed as Bell's palsy. He told that it would go off automatically without any treatment. It did not happen. Finally a professor of medicine performed decompression surgery. In spite of that she suffered permanent residual disability as already the condition had worsened due to delay in performing the procedure. The court recorded a verdict in favour of the patient. It observed that the duty of a general practitioner or a specialist to disclose was limited to matters which a reasonably knowledgeable general practitioner or specialist ought to know. Here the court found that the doctor failed to know the matters a reasonably knowledgeable practitioner ought to know.

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[64] *Jefferies* v. *McCague*, 363 A. 2d 1167, Pa 1976.

[65] *Ibid.*

[66] *Morrison* v. *Mckillop,* [1977] 2d 220, Wash. P. 63.

(iii) *Disclosure of known material risks:* The doctrine of informed consent is based on the premise that every medical procedure is beset with inherent risks.[67] As such a doctor is under a legal obligation to divulge the known material risks failing which he invites liability. In *Reibel* case,[68] a patient underwent a surgery for removal of occlusion in the left internal carotid, which had prevented more than 15% of blood through the vessel. The surgery involved risk of death (4%) and stroke (10%). But those risks were not informed to the patient. The patient got paralyzed and impotent as a result of the operation. The court held the doctor liable on the ground that the doctor failed to disclose the inherent material risks.

There is however, a significant difference in the nature of express consent of the patient, known as 'real consent' in UK and as 'informed consent' in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and 'real' when (i) the patient gives it voluntarily without any coercion, (ii) the patient has the capacity and competence to give consent, and (iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consented to. On the other hand, the concept of 'informed consent' developed by American Courts, while retaining the basic requirements consent, shifts the emphasis to the doctor's duty to disclose the necessary information to the patient to secure his consent.

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[67] Emily Rubin, *Ineffective Assistance of Counsel and Guilty Pleas: Towards a Paradigm of Informed Consent,* 80 VLR 1699 at 1710 (1994).

[68] *Reibel* v. *Hughes* [1980] 1 14 DLR 1.

In *Canterbury* case,[69] the US Court of Appeals, District of Columbia Circuit, emphasized the element of Doctor's duty in 'informed consent' thus:

> It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment. It is also clear that the consent, to be efficacious, must be free from imposition upon the patient. It is the settled rule that therapy not authorized by the patient may amount to a tort – a common lay battery – by the physician. And it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification. Thus, the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient.

The basic principle in regard to patient's consent may be traced to the following classic statement by Justice Cardozo in *Schoendorff* case:[70]

> *Every human being of adult years and sound mind has a right to determine what should be done with his body; and a surgeon who performs the operation without his patient's consent, commits an assault for which he is liable in damages.* [Emphasis added]

This principle has been accepted by English courts also. In *Re: F* [71] the house of lords while dealing with the case of sterilization of a mental patient reitered the fundamental principle that every person's body is inviolate and performance of a medical operation on a person without his or her consent is unlawful. It was held that the additional or further treatment which can be given (outside the consented procedure) should be confined to only such treatment as is necessary to meet the emergency, and as such needs to be carried out at once and before the patient is likely to be in a position to make a decision for himself. Lord Goff observed:

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[69] *Canterbury* v. *Spence*, 1972 [464] Federal Reporter 2d 772.

[70] *Schoendorff* v. *Society of New York Hospital* (1914) 211 NY 125.

[71] In *Re: F*, 1989 (2) All ER 545.

> Where for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures.[72]

English law has recognized a positive duty of warning risks, which is equivalent to the doctrine of informed consent. The extent and standard of disclosure is governed by the *Bolam*[73] principle which reads as follows:

> A doctor is not guilty of negligence if he has acted in accordance with a practice which is accepted as proper by a responsible and respectable body of medical opinion. Accordingly, the content of information to be divulged depends upon the practice accepted as proper by a responsible body of medical opinion.

A doctor would be held guilty of negligence if a responsible and respectable body of medical men had disclosed the same. In effect, the standard of disclosure is left to be determined in accordance with the professional standard. The prudent patient test, which is recognized in other jurisdictions, could not find favour with the English courts. However in *Sidway* case,[74] the court declared that when specific information is solicited by the patient, the doctor is bound to answer truthfully and fully. Interestingly, in an Australian *Rogers* case,[75] the court sought to distinguish between diagnosis, treatment and information disclosure and stated that *Bolam* standard may apply to the former two but not to the last. It was held that the appropriate standard of disclosure is a matter for the courts to adjudicate on and not for the medical fraternity to settle. It was until the case of *Bolitho*[76], that a slight revision in the test laid down by *Sidaway* was considered which tackles the undesirability of the medical community collectively laying down standards for themselves. The Bolitho decision declared that the judge must be satisfied that the medical opinion relied upon (under *Bolam* standard) is reasonable and reliable. This is thus the modified *Bolam* standard and has applied in several cases since the Bolitho decision. The test that prevails in England thus is a variant of the reasonable doctor test in the United States.

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[72] Ibid.

[73] *Supra* note 19.

In Nepal, the Court of Appeal in *Surya Kumari Adhikari* Case[77] quashed and declared previous decision by DCC as defective and forwarded the case file back to DCC to re-decide as the previous decision was based on defective expert opinion. Indeed expert opinion in the case file was unclear because of the absence of name and signature of expert who gave the opinion. The court opined that technical medical questions can only be answered and resolved by consideration of expert opinion and in doing so the court relied on *Bolam* principle.

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[74] *Sidway* v. *Board of Governors of Bethlem Royal and the Maudsley Hospital* [1985] 1 All ER 643 (H.L.).

[75] *Rogers* v. *Whittaker* [1992] 109 ALR 625.

[76] *Supra* note 20.

[77] *Surya Kumari Adhikari* v. *Paropakar Maternity and Gyno Hospital Development Committee*, AC Patan, CD: 2009/09/17, DD: 2010/09/26.

Now considering the nature of information that is required to be furnished by a doctor to secure a valid or real consent, in *Bowater* case,[78] Scott L.J observed:

> A man cannot be said to be truly 'willing' unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing shall interfere with the freedom of his will.

In *Salgo* case,[79] it was held that a physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. The Canterbury case explored the rationale of a doctor's duty to reasonably inform a patient as to the treatment alternatives available and the risk incidental to them, as also the scope of the disclosure requirement and the physician's privileges not to disclose. It laid down the 'reasonably prudent patient test' which required the doctor to disclose all material risks to a patient, to show an 'informed consent'. It was held:

> True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable

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[78] *Bowater* v. *Rowley Regis Corporation* [1944] 1 KB 476.

[79] *Salgo* v. *Leland Stanford*, 154 Cal. App. 2d 560 (1957).

divulgence by physician to patient to make such a decision possible.

It is thus, the patient's right of self-decision which shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communication to the patient then must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular pearl must be divulged is material to the patient's decision: all risks potentially affecting the decision must be unmasked. Further, a risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy. The doctor, therefore, is required to communicate all inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the likely effect if the patient remained untreated. This stringent standard of disclosure was subjected to only two exceptions: (i) where there was a genuine emergency, e.g. the patient was unconscious; and (ii) where the information would be harmful to the patient, e.g. where it might cause psychological damage, or where the patient would become so emotionally distraught as to prevent a rational decision.

4. Legal Remedies on Medical Negligence in Nepal

In every profession, person possesses some degree of immunity and privileges during the discharge of their professional responsibility. Professionals are not an employee who work what they are told to do or have been ordered to do. They are required to exercise their prudence, best knowledge, experience, skill and diligence. Professionals act under their personal capacity. They work in good faith, due diligence and are always concerned to serve best interest of their patient. In case any damage or harm is resulted to the victim without any default of the medical practitioner in fulfillment of duty of care, no liability will be accorded to them. This would not amount to medical negligence.

Negligence in medical care may broadly be classified into four levels of treatment: (1) Medical negligence at the level of doctor/paramedical staff/ hospital authorities. Liability for negligence may be fixed at individual level and/or jointly or vicariously where hospitals/nursing homes are involved. (2) Negligence at the level of manufacturers of drugs, equipment, etc. and dispensers. (3) Negligence at the level of patient himself or his attendants also known as *contributory negligence* and (4) Composite negligence, i.e., at more than one of the above three levels.

Consumer Protection Act, 2075 B.S is a specific law that deals with medical negligence compensation claims in Nepal. The purpose of Act is to implement constitutional guarantee[80] of every consumer to obtain quality goods and services and recognize right to obtain lawful compensation against injury suffered from any substandard goods or services.

"Medical Negligence" has not yet been defined by any law in Nepal. Complaints related to Medical Negligence are entertained and adjudicated as "compensation cases" under Consumer Protection Act, 2075 B.S. Patient should suffers loss or damage as a result of any "deficiency of service" in the part of medical service provider(s) for getting remedy under the Act.

"Consumer" [81] as defined by the Act denotes any person or institution that consumes or uses any goods or services. Patients are the consumers and customers of medical goods and medical services. The term "service" as defined in the statute includes health and medical services as well.[82] It defines "defective product/service".[83] It acknowledges right of every patient consumer to obtain quality health care service.[84] Patient has right to make choice among quality medical services.[85] Every patient is entitled with right to be informed of the price, quantity, purity, quality etc. of medical goods or services.[86] Every patient has right to be safe against health care goods and services harmful to human body, life, and health.[87] Right of every patient consumer to initiate appropriate legal action against improper and commercial medical activities has also been guaranteed.[88]

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[80] Article 44 of the Constitution of Nepal, 2072 B.S.

[81] Section 2(d) of Consumer Protection Act, 2075 B.S.

The Act recognizes right of every patient consumer to obtain compensation against harm or loss caused by use of defective medical goods or services.[89] Aggrieved patient has right to obtain remedy or hearing from authorized body in regard to the protection of consumer rights and interest as per Section 3(h). The Act mandates concerned district court to exercise ad hoc jurisdiction on medical negligence complaints till government establishes consumer court in Nepal[90]

Complaint of compensation against medical negligence is to be filed at concerned district court either by (i) consumer or (ii) consumer institution on behalf of consumer or (iii) legal heir in case of inability or death of consumer, within 6 months from date of loss, whether bodily, mental, economical, physical, or any other loss.[91]

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[82] Ibid Section 2(q)
[83] Id Section 2(r)
[84] Id Section 3(1)
[85] Id Section 3{2}(b)
[86] Id Section 3{2}(c)
[87] Id Section 3{2}(e)
[88] Id Section 3{2}(f)
[89] Id at Section 3{2}(g)
[90] Id Section 41 and 48.

Necessity to prosecute medical professionals for criminal negligence arises in a limited situation. This is dealt under the provisions of crimes relating to Medical Treatment in *Muluki* Criminal Code, 2074 B.S. (2017). Section 232 prohibits and criminalizes act of prescribing medicine or carrying surgery with *laparbahi* & *helchakrayai* by licensed person. In case of death due to *laparwahi purna kaam,* the punishment extends up to 5 years imprisonment and up to Rs 50,000/- fine. If such negligent treatment (*helchakrayai gareko karanbata*) causes death or grievous hurt, punishment would be up to 3 years imprisonment and up to Rs 30,000/- fine.

What is the difference between "*laparwahi*" and "*helchakrayai*" has not been clarified and defined by the law. However, difference in punishment has been announced presuming *laparbahi* as an offence with higher gravity than *helchakrayai*. From this disparity in the degree of punishment, it can be presumed that legislative intention to use the term *laparwahi* is "recklessness" and *helchakrayai* is "negligence"

Under the previous consumer law, there was a system of adjudication of medical negligence compensation disputes through District Compensation Committee that comprised of bureaucratic composition and thus was ineffective. Highlighting this scenario, Supreme Court in *Dr. D.B. Shah* case[92] had directed to adopt alternative measures where such technical disputes would be decided by members having expertise in same field. Once consumer court gets established, the author recommends to create 'medical law bench' (same like juvenile bench formed in district court) with mandate to adjudicate medical negligence compensation disputes for delivering specialized judicial service. Only the judges who have developed expertise or received specialized training in medical law and medical negligence jurisprudence ought to be mandated to sit as judge into such medical law bench.

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[91] Id at Section 50

[92] Supra Note 3.

Due to lack of non specialization of District Compensation Committee members in technical nature dispute of medical negligence, numerous blunders have already been committed. An example is of *Gandaki Medical College* case[93] where, patient party was awarded compensation under civil liability by applying Section 18 of the then Consumer Protection Act, 2054 B.S. that would be applicable only for penal liability. Indeed the Committee had to grant compensation standing on section 22 against the doctor. This reflects gross legal negligence or ignorance of District Compensation Committee members regarding the idea of exact legal provisions applicable for providing civil and criminal remedy.

Courts have been expressly recognizing direct liability of doctor and vicarious liability of hospital in case of medical negligence. In *Kiran Basnet* case,[94] error in diagnosis by employee doctor leading to wrong conclusion about patient's health condition made the examining doctor and clinic liable for medical negligence.

5. Security of Health Professionals and Health Institutions

Health Professionals & Health Institutions Security Act, 2010 & Regulation, 2012 are the specific laws that provide security to health care providers. As the name itself suggests, the Act is meant to: (a) make necessary legal provisions for the security of health workers and health organization against casual incidents and economic liabilities that may arise in course of medical treatment, and (b) make health services regular, reliable, decent and effective. The term 'security' as per the Act denotes not only physical security but even financial and other securities to health professionals/ institutions.

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[93] *Gandaki Medical College* v. *Narayan Bahadur Bohara*, AC Pokhara, DB, 2012/09/11

[94] *Kiran Basnet* v. *Dr. Buddha Basnet*, DCC Kathmandu, CD: 2006/8/2 DD: 2009/05/28

Criminal activities such as manhandling, lock-out and destruction are prohibited by section 3 of the Act and anyone violating these provisions are liable for punishment. No one is allowed to do or cause to be done: (a) Besieging *(gherau)*, manhandling or doing degrading treatment to any health worker on the issue of medical treatment. (b) Destructing, setting fire to, any health organization or doing similar other acts. The Act is victim friendly as it even has provisions for compensation to the one who suffers loss of property due to such attacks. The law creates range of liabilities for violating the provisions of the Act.

While interpreting the provisions of this Act, courts should always remain aware that not always patient (party) attacks doctors willingly but under emotion or when doctor had not treated patient with degraded performance generating lure of high expectation in patient's mind. Lack of informed consent treatment or failure to inform the chances of success and possible sideeffects of treatment are also to be considered prior to interpreting the provisions of this Act and prior to imposing punishment to the patient party. Dr. Jagadish Prashad Aggarwal, former Executive Director, Institute of Medicine acknowledges lack of communication (doctor-patient) and skill in physicians is the major cause of vandalism in hospitals. Likewise, he claims two other reasons of vandalism include: (i) lack of medical knowledge in doctors, (ii) disobedience of Rule of Law in society.[95] Patients treat doctors as God whereas doctors present themselves as businessmen before patients. This inconsistency is the cause of vandalism.[96] 80% physicians in Nepal lack communication skills.[97] It would be relevant to discuss an opinion by a physician regarding poor doctor-patient communication as the major cause behind vandalism and attacks on health professionals or institutions:

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[95] *National Monthly Health Newspaper*, Nepal, *Poush* 2068 B.S., p.9

No other persons can give security to others. Physicians should themselves provide full counseling to patient party about treatment expenses, possible complications of treatment, method of treatment, necessity of referral, reason for referral, referred to which doctor etc. prior to starting treatment which will prepare patient party mentally ready to face the consequences and risks inherent in such treatment. The purpose of counseling is to enable patient party to make choice and self-decision regarding whether to carry treatment or not, with whom to undergo treatment etc. This campaign needs to be widely practiced. The aim of physician is to serve the patients and it is a matter of pride to every physician. Physicians who aim to earn money should never forget that money can be earned only if the professional ethics and standards are complied.[98]

Section 4 of the Act provides duty of local administration (to arrange for security immediately) and government (if finds permanent arrangement of security is necessary to prevent obstruction in the services provided by any health organization) to arrange for security immediately upon demand by health worker or health institution. Any health worker or health organization who intends to have security pursuant to this Act should register his/her name before the committee by paying fees as prescribed annually as stipulated in section 7 and 8 of the Act.

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[96] Jyoti Baniya, Consumer Interest Protection Forum. (Source: *National Monthly Health Newspaper*, Nepal, *Poush* 2068 B.S., p.12.)

[97] Research conducted by Prof. Dr Jagadish Aggarwal, IOM (Source: Supra note 27 at p. 10)

[98] Dr. Kiran Prashad Shrestha, President, Nepal Medical Association (Source: *National Monthly Health Newspaper*, Nepal, *Falgun* 2067 B.S., p. 40).

Section 5 and 6 of the Act establishes Health Worker and Health Organization Security Coordination Committee to: (a) approve plans and programmes relating to the security of the health workers and health organizations and implement, or cause to implement such plans and programs, (b) maintain coordination between the concerned bodies as to the security of the health workers and health organizations, (c) provide compensation on behalf of the health workers and health organizations to the concerned persons pursuant to court judgments, (d) give suggestions to the government in respect of the policies to be pursued on the security of the health workers and health organizations.

Health Professionals and Health Institutions Security Regulation, 2012 creates duty on local administrator to provide security (for reasonable time by evaluating the situation) to those health professional(s) or health institution(s) who have demanded reasoned urgent security need. In case of necessity for arrangement of permanent security the applicant has to bear lodging and food expenses of the security person. Health institution can also get approval to use separate means of communication from Health Ministry (with consent from Ministry of Communication) as per Section 3 and 4 of the Act.

Health professionals or institutions seeking security are required to register their name paying Rs 500/- as application fee and should pay annual fee to Health Professionals and Health Institutions Security Coordination Committee (private health institutions are required to pay double fee). Health Professional or Health Institution can submit application to receive compensation amount as decided by court or litigation cost for payment within 3 months from date of court's decision. Ministry of Health is authorized under Rule 16 to draft and enact required Code of Ethics for Health Professionals upon the recommendation of the Committee to comply with which would be duty for all health professionals.

C. Doctrine of res ipsa loquitor

Res ipsa loquitor is no more than a convenient label to describe situations where, notwithstanding the plaintiff's inability to establish the exact cause of the accident, the fact of the accident by itself is sufficient, in the absence of an explanation, to justify the conclusion that most probably the defendant was negligent and that his negligence caused the injury. The general purport of the words *res ipsa loquitor* is that the accident speaks for itself or tells its own story.

The normal rule is that it is for the plaintiff to prove negligence, but in some cases considerable hardship is caused to the plaintiff as the true cause of the accident is not known to him, but is solely within the knowledge of the defendant who caused it, the plaintiff can prove the accident but cannot prove how it happened to establish negligence on the part of the defendant. This hardship is sought to be avoided by invoking the principle of *res ipsa loquitor.*[99]

Where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendant, that the accident arose from want of care.

The maxim comes into operation: (a) on proof of the happening of an unexplained occurrence; (b) when the occurrence is one, which would not have happened in the ordinary course of things without negligence on the part of somebody other than the plaintiff, and (c) the circumstances point to the negligence in question being that of the defendant, rather than that of any other person. Some of the examples are amputation of wrong limb or wrong digit at operation, burning of skin caused by strong antiseptic solution, leaving swabs or surgical instrument inside the patient after the operation. The onus lies on the doctors in the operation theatre to explain events and the ultimate outcome, i.e., the death of the patient.[100] When keratotomy operation was performed on left eye of a teenager in violation of accepted professional practice, resulting in loss of his eyesight, the burden of proof is on the doctor to establish that he was not in breach of any duty in giving treatment to the minor patient.[101] The onus of proof shifts upon the attending doctors to prove that there was no negligence in performance of operation when the patient died within 10 hours of admission in the operation theatre in mysterious circumstances.[102] Where the complainant is not aware of what took place inside the operation theatre, the onus of proof lies on the doctor to establish that there was no negligence on his part resulting in permanent disability of the patient.[103]

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[99] *Pushpabai Parshottam Udeshi v. M/s Ranjit Ginning & Pressing Co. Pvt. Ltd.*, AIR 1977 SC 1735.

In *Bhanupal* Case,[104] it was observed that the patient's relatives must prove positive act of omission but they need not produce evidence to establish the standard of care if the entire operative procedure was carried out in the absence of any of the patient's relatives. Naturally, when all such medical or surgical procedure was carried out inside the operation theatre when nobody on behalf of the patient was present, the patient's relatives were unable to see any kind of medical / surgical procedure or what exactly happened inside the operation theatre. Therefore, the opposite parties and the staff attending inside only had special knowledge of what happened inside the operation theatre and the complainant is not in a position to exactly state the factual aspects of whatever took place inside. Therefore, it was a duty cast upon the opposite parties to prove the fact that no sort of negligence took place inside the operation theatre. Thus, the onus of proof shifts upon the opposite parties to substantiate the fact that there was no negligence on their part.

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[100] *Arunaben D. Kothari v. Navdeep Clinic,* 1996 (3) CPR 20 (Guj).

[101] *Adarsh Bararia v. Dr. P.S. Hardias,* 2002(2) CPR 188 (Bhopal).

[102] *Bhanupal v. Dr. Prakash Padode,* II(2002) CPJ 384 (Bhopal).

[103] *S.A. Qureshi v. Padode Memorial Hospital and Research Hospital,* II (2000) CPJ 463 (Bhopal).

[104] *Bhanupal v. Dr. Prakash Padode,* II(2002) CPJ 384 (Bhopal).

In *Nadiya* case,[105] the complainant approached the opposite party hospital for surgery for increasing the height. She underwent Corticotomy with external fixator. However, after the surgery, her left leg remained 1 ½ inch shorter than the right leg. She needed the aid of walker as she had to lean on the left. It was contended by the hospital that the complications suffered by the complainant resulted due to her failure to adhere to the instructions of the doctors. It was held that the burden shifted to the opposite parties to substantiate their case.

In *Mahon* Case,[106] a majority of the court of appeal considered that the doctrine of *res ipsa loquitor* applied. Goddard L.J. said:

> The surgeon is in command of the operation, it's for him to decide what instruments, swabs and the like are to be used, and it's he who used them. The patient, or, if he dies his representatives, can know nothing about this matter. There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient's body and no one would venture to say that it's proper, although in particular circumstances it may be excusable, so to leave them. If, therefore a swab is left in the patient's body after an operation, it seems to be clear that the surgeon is called for an explanation.

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[105] *Nadiya v. Proprietor, Fathima Hospital and ors.* (2001) II CPJ 93.

[106] *Mahon v. Osberne* (1939) 2 K.B. 14.

In *Siverson* case,[107] the defendant, a specialist in gynaecology, assisted by a general surgeon, performed a hysterectomy on the plaintiff. After the operation plaintiff was found to have a vesicovaginal fistula. Plaintiff instituted action, but did not call expert witnesses. Plaintiff relied on defendant's answer that usually when a gynaecologist exercised that degree of skill and care ordinarily exercised by a reputable gynaecologist, a fistula does not follow a hysterectomy, and that a fistula is an uncommon complication. The court held that to permit an inference of negligence under the doctrine of *res ipsa loquitror* merely because an uncommon incident takes place would amount to stretching the doctrine too far.

A doctor is neither a warrantor of cures nor an insurer, where reasonable doubt exists as to the proper treatment to pursue, an inference of negligence is not ordinarily raised from honest mistakes or errors in judgment. Another rejection of the doctrine in dentistry is reported in Indiana in *Robinson* case,[108] where plaintiff brought an action against defendant who was a dentist for alleged negligence in breading a hypodermic needle, and allowing it to remain in plaintiff's Jaw. The court said that *res ipsa loquitor* was not applicable in the absence of evidence that the needle was defective, not of a type commonly used by dentists, used in a careless way or that the defendant was negligent in inserting the needle into the jaw of the plaintiff.

The Supreme Court applied the doctrine of *res ipsa loquitor* in *Achutrao's* case,[109] where the patient had to undergo second operation in critical condition for removal of a mop (towel) left inside the peritoneal cavity of the patient during sterilization operation in a Government hospital. The High Court of Rajasthan in *Rajmal* case,[110] also invoked the doctrine of *res*

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[107] *Siverson* v. *Weber*, 57 Cal.2d 834.
[108] *Robinson v. Fuguson* [107, Ino App, 107 (1939).
[109] *Achutrao, Haribhau Khodwa v. State of Maharashtra*, (1996)2 SCC 634.
[110] *Rajmal v. State of Rajasthan*, 1996 ACJ 1166.

ipsa loquitor to hold the State Government liable for the death of a patient during laparoscopic tubectomy operation in the Government hospital. The State Commission, Karnataka in *Ambalappa* case,[111] held the dental surgeon liable in negligence for slipping of needle into the stomach of the patient at the time of irrigation the mouth after extraction of right molar teeth of the patient by applying the principle of *res ipsa loquitor,* as the surgeon could not explain as to why the needle was detached from the syringe while irrigating mouth of the patient.

The Supreme Court in *Savita Garg* case[112] held that once evidence is placed by the complainant to satisfy that the patient admitted for treatment after taking him to intensive care unit developed jaundice and died because of lack of proper care and negligence, then the burden shifts to the hospital and the doctor who treated the patient to satisfy that there was no negligence on the part of doctor or hospital. It would be too much of a burden on the patient or the family members to undertake searching enquiry from the hospital to ascertain the names of treating doctors or the staff and to show who was responsible for the death. The hospital is in better position to disclose what care was taken or what medicine was administered to the patient.

Recently the Supreme Court held that in a case where negligence is evident the principle of *res ipsa loquitor* operates and the complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence.[113] In *Manwari Devi* case,[114] and *Illath*

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[111] *Ambalappa v. Sriman D. Veerendra Heggade,* 1999(3) CPR 72 (Bangalore).

[112] *Savita Garg v. The Director, National Heart Institute* [2004 CTJ 1009 (SC).

[113] *V.Krishan Rao* v. *Nikhil Super Speciality Hospital* (2010) 5 SCC 513.

[114] *Manwari Devi* v. *Union of India,* AIR 2010 (NOC) 651 HP.

Narayanan case,[115] the sterilization operation failed and claimant got pregnant. Claimant failed to produce evidence to show negligence in matter of performing operation. The court held that in absence of proof of negligence, claim for damages is not tenable by invoking principle of *res ipsa loquitur.*

6. Criminal Negligence versus Civil Negligence

Generally, medical negligence results into civil or tort liability. Compensation is adequate remedy for civil or tortuous negligence. Only in rare instances of medical negligence, charge-sheet is framed by prosecutor demanding imprisonment or and fine against negligent health professional as a subject matter of criminal liability. The culpability of negligence is determined by mental element of health care provider. What amounts criminal negligence is determined by criminal law of the land. Jurisprudentially, for medical negligence to be criminal in nature and for falling under the subject matter of prosecution, medical negligence must fall under either of the following four criteria or nature: (i) intended harm is inflicted to patient (*niyatpurbak*), or (ii) grave indifference towards value of human life of patient despite knowledge that his action might take life of patient (*jani jani*), or (ii) serious disregard to the life of patient that is not expected from reasonable medical professional (*biramiko jyaan prati gambhir bewasta*), or (iii) gross negligence or high degree negligence or reckless act resulting into death or serious loss or grievous hurt to patient (*charam laparbahi*).

Some common examples of gross negligence that could be subject matter of prosecution include- death of patient due to denial of emergency treatment despite having medical facility to treat just because of fear of being dragged into litigation in case patient dies, surgery of wrong patient, surgery of different site in same patient, leaving foreign materials (cotton gauge, needle, scissors etc) inside the body of patient during surgery, performing surgery that was not necessary as per medical science and so on. Numerous examples of criminal medical negligence have been enlisted in an author involved four membered Expert Committee Report [116] submitted to Government of Nepal.

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[115] *State of Kerala* v. *Illath Narayanan*, AIR 2010 (NOC) 652 Ker.

Section 232 of *Muluki* Criminal Code, 2074 B.S. prohibits treatment with *laparbahi* & *helchakrayai* according to which no medical professional can treat, prescribe medicine or operate without taking adequate precaution. Such negligent treatment (*laparwahi purna kaam*) if leads to death, punishment would be up to 5 years imprisonment and up to Rs 50,000/- fine. If such negligent treatment (*helchakrayai gareko karanbata*) causes death or grievous hurt, punishment would be up to 3 years imprisonment and up to Rs 30,000/- fine. What is the difference between "*laparwahi*" and "*helchakrayai*" has not been clarified and defined by the law. However, difference in punishment has been announced presuming *laparbahi* as an offence with higher gravity than *helchakrayai.* From this differential degree of punishment, it can be presumed that legislative intention to use the term *laparwahi* is "recklessness" and *helchakrayai* is "negligence". There should be no space for assumption and presumption in criminal law. The sections are awaiting amendments to add explanations and illustrations what exactly is *laparwahi* and *helchakrayai.* The author's article[117] published in Kantipur daily national newspaper provides detail guidelines regarding what changes are to be made in this law, and what

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116Gross Medical Negligence Investigation, Enquiry and Compensation Advisory Report, 2017 was submitted to Ministry of Health on 17 October 2017 (2074-06-31 B.S.). (The 4 membered committee was established as per Cabinet decision by Ministry of Health's mandate dated 24 Sept. 2017)

117Dr. Ramesh Parajuli; Medicine of Medical Law (*chikitsa kanoonko aausadhi*), Kantipur Daily National Newspaper, 11 September 2018, p 7.

should be the exact languages and words in such explanation.

In criminal negligence, a person acts in a particular way which is an extreme departure from which a reasonable person would act in a similar or same circumstance. Whereas, in civil negligence the conduct is not seen as a radical departure from the way a reasonable person would have responded.

In civil negligence, a person fails to exercise ordinary care or due diligence. Whereas, criminal negligence relates to a conduct that is considered so extreme and rash that it is a clear divergence from the way an ordinarily prudent person would act and is considered to be more than just a mistake in judgment or distraction.

In civil negligence, there is a lesser burden of proof because the plaintiff in such a case only has to prove that it is most likely that the defendant was negligent. But in criminal negligence, the plaintiff has to prove "beyond a reasonable doubt" that the defendant was negligent. Here, the evidence is so strong that there is no other logical explanation besides the fact that the defendant acted with criminal negligence.

The punishment for a person who was liable in a civil negligence is compensation for damages to the immediate victim patient. In criminal negligence, punishment is much more serious and can be convicted for a prison term or fine or other alternative provided by sentencing law. In India, criminal negligence if causes death is punishable with upto 2 years imprisonment or fine or both under section 304A of IPC.

If someone drives a vehicle in high speed under the influence of drug or alcohol hits pedestrian to death, it amounts to criminal negligence as this involves extreme carelessness or recklessness.But if a housekeeper in an office is mopping the floor and forgets to keep a 'wet floor' signboard, as a result, some accident occurs, that is an example of civil negligence because there is only a lack of due diligence on the part of the housekeeper, not extreme neglect.

7. Judicial Views on Medical Negligence

Falling of medical profession within the ambit of Consumer Protection Act was recognized for the first time by Nepalese Supreme Court in *Dr. D.B. Shah* case.[118] As per the then statute,[119] for activation of the concept of liability, there must be some loss suffered to patient. In *Dr. Buddha Basnet* case[120] the Court of Appeal also recognized loss to patient as a prerequisite for imposing liability to medical professional under negligence where it was observed "if patient (consumer) has not suffered any loss despite breach of duty by service providers, it cannot be claimed under Consumer Protection Act." However, in *Tika Prasad Adhikari* case,[121] the Court of Appeal held hospital vicariously liable for the court foresaw the certainty of loss to patient, due to negligence of lab technician in finding out actual blood group of admitted patient in need of blood for transfusion. The fact was disclosed after the patient was transferred to another hospital where blood group was re-identified. The court held- 'Identifying wrong blood group of admitted patient for the purpose of blood transfusion prior to surgery amounts to medical negligence (even if blood could not be transfused because patient was transferred to another hospital having required facility) and makes Hospital management liable.'

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[118] *Supra* note 3.

[119] Section 22 of the then Consumer Protection Act, 1998 provided: "In case any consumer suffers a loss or damage of any kind as a result of the sale of any consumer good or service contrary to this Act, such consumer, or any Consumer Association on behalf, may file a complaint with the Compensation Committee..."

[120] *Dr. Buddha Basnet* v. *Jyoti Baniya,* AC Patan, DD: 2010/09/26.

[121] *Tika Prasad Adhikari* v. *Om Hospital & Research Center Pvt. Ltd.,* DCC Kathmandu, CD: 2006/11/13, DD: 2010/4/23.

In *Dr. D.B. Shah* case, District Compensation Committee recognized both D1 and his clinic (D2) liable for medical negligence and the Patient (P) was awarded Rs 1,17,119.94, treatment expenses (as compensation) even if P had claimed Rs 18,73,750. Appellate Court also held the defendants D1 and D2 liable for negligence but awarded additional amount of Rs 5, 00,000/- to P as compensation to be paid equally by D1 and D2. Supreme Court finally upheld the same decision of appeal court.

Principles established by Supreme Court:

i. Citizen's right to obtain health treatment and right to health both are fundamental rights. Every patient should be entitled to right against medical negligence and must have right to adequate compensation for proven medical negligency.

ii. Loss of eyesight and disfiguration of patient due to the failure of doctor to provide written information about the possible side effects of drugs prescribed along with information to consult the doctor immediately after symptoms of side effect start appearing makes the doctor liable for medical negligence.

iii. Failure of hospital/health care centre, clinics and nursing homes to monitor the work performance of its employee doctor and staffs makes the management liable for medical negligence.

iv. Failure of duty to provide quality medical service leading to medical negligence makes doctor, hospital and health care centre, clinics and nursing homes liable.

v. Loss of eyesight due to medical negligence violates right to Life and Livelihood of patient. Every patient should be entitled to right against medical negligence and must have right to adequate compensation for proven medical negligence.

vi. Limitation starts neither from the date of examination/ prescription of drugs by doctor nor from the date of starting to take drug by patient but from the date of knowledge to patient of being victimized by negligence after the symptoms start getting visible.

vii. If doctor treats patient with dedication applying his experience, skill, education, efforts and knowledge and despite that treatment fails or patient dies, doctor cannot be held guilty for medical negligence.

viii. Doctor-patient relationship is a sensitive one. A doctor always tries his best to properly diagnose the disease and save life of his patient which is globally a recognized principle. As a rule, courts always presume that a doctor never intends to have malafide intention towards his patient. If any patient alleges of medical negligence by doctor, it is the patient's duty to prove his allegation. It is to be presumed that a medical negligence alleged doctor is innocent until his guilt is proved/established by competent court. If courts blindly decide doctor liable on medical negligence simply in case of death or injury to patient then doctors will try to avoid risk and concentrate more on defensive medical practice and concentrate more on their own security measures so as to avoid being dragged to litigation.

ix. Doctors and patients owe certain mutual duties to each other. It is both the Ethics as well as Code of Conduct for every Doctor that requires them to treat patient with bonafide intention. Small negligence on the part of doctor may take life of patient or damage any organ of patient's body permanently. Thus doctors have accountability towards patients. Likewise, patients also have certain duties viz- a) disclosing every information related to one's disease to doctor, b) disclose with which doctor had the patient consulted for what disease and undertook which medication for how long time period, c) take medicines regularly as prescribed by doctor.

x. It is the duty of doctor to record medical history of patient prior to treatment in written form regarding which doctor had examined the patient prior to him, what was the disease and what medication had the patient gone through.

xi. No doctor or hospital who/that examines patient at 11th hour can be liable for medical negligence simply for the death of such patient in three conditions viz- (a) if patient had not started treatment in time as informed/recommended by doctor, (b) if patient visits to doctor or hospital after disease gets chronic at last stage, and (c) if patient neglects own illness and visits to other non specialist doctors in the beginning and later on rushes to the specialist doctor at the last stage after situation goes worst.

xii. The amount of compensation to victim should be determined keeping into consideration over the age, financial status, loss of her eyesight, disfiguration of her body and mental agony to the patient even though actual loss suffered by the patient cannot be evaluated in terms of money.

Other Discussions by Supreme Court:

1. Doctor patient relationship is seen in two approaches viz- (a) *Professional standard of care.* This is a traditional assumption which believes howsoever a doctor treats, he always treats patient with full dedication, honesty, with good faith and for the best interest of the patient. Therefore consent of patient is considered irrelevant prior to treatment as per this approach. (b) *Informed Consent Theory.* It is the modern theory evolved after 1960s which acknowledges every patient as the ultimate owner of his/her own body and hence only the patient has right to decide which mode of treatment to undergo in his body. A doctor has no right to

make a choice on patient's body rather doctor is dutybound to inform every detail (For example, what has happened to patient? Which disease is it? What method of treatment should be done? What are the risks and sideeffects associated with such method of treatment? What happens if treatment is not done? etc.) about disease to the patient and take patients' consent prior to starting treatment then only doctors cannot be made accountable afterwards. This informed Consent Theory replaced Professional Standard of of Care Theory after 1960s and it makes doctors more accountable towards patients while simultaneously allows patient opportunity to be aware and be informed what is happening with him/her.

2. Private clinic is vicariously liable under tort for negligence. Clinic as a legal person incorporated according to law with objective to treat patients cannot be immune from liability after it is dragged into medical negligence allegation. The reasons put by court were:

   a) Blue Cross Clinic (D2) has been delivering drugs service through doctors.

   b) The purpose for establishment of clinic (D2) as reflected in its Memorandum and Article of Association is clearly "to treat patients".

   c) It is seen that doctor D1 had not treated patient in his individual capacity rather the prescription shows that he used to sit in the clinic and treat/check and prescribe medicine to patients using status of clinic as well.

   d) "Service" provided by doctor, hospital and clinic falls under the definition of section 2(e) of CP Act and "consumer" under section 2(a) of the Act includes even patients.

   e) Patients visit and come for treatment to clinic because of clinic's goodwill as well.

f) Thus as government hospitals are liable under tort for medical negligence done by their doctors, likewise, private nursing homes are also equally liable and thus the compensation amount ought to be borne by doctor and private nursing home equally.

3. Supreme Court also analysed the then existing statutes that were related to medical negligence. To put in courts words:- "Even if Chapter on treatment in Country Code has to some extent criminalized medical negligence, it has no legal provisions that enlist duties of doctor towards patients, what ought to be doctor-patient relationship and what right does a patient have to be informed regarding his disease/treatment. NCP Act has covered medical treatment within the meaning of "service" and in case if medical negligence is proved, it provides for fine and compensation under tortuous liability and criminal prosecution under criminal liability of the doctor. Act has not provided mutual rights and duties of doctor and patient nor does it define the term medical negligence. Likewise, no Nepalese law and case law has till today made any discussion or provided guidelines regarding legal relationship between doctor and patient ... There are many instances beyond control of doctor where patient may die despite best efforts of doctor to save his life and doctor cannot be liable for this but there may be other instances of negligence, Carelessness and Recklessness causing harm or death to patient. The trend of suing doctor and hospital for compensation seem rising these years. In this regard, current Chapter on Treatment in Country Code seems inadequate to cope the necessities of present. Likewise, CPA is more inclined and designed to regulate quality and competition of goods and other edibles rather than addressing medical negligence issue. Thus a

modern Self Contained Act has been felt necessity to govern doctor-patient relationship."

4. Supreme Court took the then prevailing defective composition of DCC under judicial notice and explained that District Compensation Committee chaired by Chief District officer that comprised of other members (district government attorney, medical officer, district consumer forum, *Udhyog Banijya Sangh*, officer appointed by government) established under section 23 of the then Consumer Protection Act is empowered to inquire and decide on medical negligence compensation complaints registered before it. However, the decision of majority is adopted and members of DCC are seen more having bureaucratic service and less indepth knowledge on medical science. Indeed, decision makers who are entrusted to resolve disputes ought to be those who possess expertise knowledge on the issue.

Directive orders issued to government by Supreme Court:

1) Directive order was issued to Nepal Government, Ministry of Health by Supreme Court[122] to enact a Comprehensive and Self Contained Medical Negligence Act guided by Theory of Informed Consent containing issues including but but not limited to: a) Limitation, b) Causation and Clinic's liability, c) Doctor patient relationship, d) Right to health and medical treatment.

2) Government was directed to constitute an Expert Committee mandated to study and give opinion to government regarding Informed Consent System of treatment practiced worldwide along with recommendations regarding what need to be done to

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[122] *Supra* note 34.

develop it in our system. The court further directed such "Committee should comprise of concerned doctor of health ministry, doctor of a government hospital, doctor of a private hospital, doctor representative of a Nepal based foreign mission hospital, doctor representative of a NMC. The Committee was required to be constituted within 3 months of obtaining a copy of this verdict and the advice of Committee ought to be implemented by Nepal government through classification of hospitals progressively within 2 years." The decision is still awaiting implementation.

3) Directed the government to establish as Expert Opinion Committee whose function will be to assist current District Compensation Committees till parliament enacts new law that will introduce technical members in the composition of present DCC. The court opined: Decision is adopted by majority and members of DCC are seen more having bureaucratic service and less indepth knowledge of medical science. Persons who are entrusted to resolve disputes and give decision need to be those who possess expertise knowledge on the issue. Further, Supreme Court pointed out "In medical negligence cases justice ought to be done based on expert opinion. DCC may take expert opinion of such committee as per necessity."

After promulgation of new Consumer Protection Act, 2075 B.S., the jurisdiction of previous District Compensation Committee has now shifted to Consumer court. In absence of consumer court, the Act mandates concerned District Court to entertain and adjudicate complaints regarding medical negligence compensation. This can be seen as a satisfactory improvement.

The Supreme Court of Nepal has decided few cases relating to medical negligence where all the negligent medical practitioners till date have been held liable to compensate patient party for civil negligence. Instances of criminal medical negligence have not yet been decided by Supreme Court.

Likewise, in *Dr. Bulanda Thapa* case[123] victim patient lost her right leg due to negligence of surgeon during surgery. She claimed compensation from the surgeon in accordance to Section 18(e)(2), 22 and 23 of the then Consumer Protection Act, 2054 B.S. The Supreme Court confirmed negligence of surgeon by upholding decision of Patan Appellate Court and imposed compensation of Rs. 9,20,000 as claimed. The court further recognized consumer has legal right to get compensation if loss or damage is suffered from wrong service or negligence of doctor.

Fact of the case shows patient (P) applicant Sushma Thapa developed neurofibroma tumor at posterior right knee. She went to BP Koirala Memorial cancer Hospital, Bharatpur on 2062/07/06; conducted X- ray; MRI conducted on 10th Kartik at Birendra Army Hospital, Chauni; seeing increase in tumor a doctor suggested need for removal surgery by writing referral letter to Dr. Buland Thapa of Bir Hospital- Dr. Thapa admitted P at Bir hospital on 13th Kartik and was aware the case is new; Defendant (D) Dr. Thapa did not visit hospital from 15th to 29th Kartik and P was discharged by hospital in absence of D; P went to Kathmandu Medical College on Magh 2nd for checkup where hospital asked P to perform MRI; P refused second time MRI and visited back to Bir hospital where P met D and on advise of D, P was readmitted on 4th Mangsir; tumor tissue sample sent for biopsy gave report on Mangsir 17th and D operated on P's right leg knee back on 24th Mangsir; next day P's right leg stopped moving; on consultation D replied- moves after 6 weeks; nurses also took it lightly and replied to keep leg warm and no need to worry; from 26th Mangsir black pigment (gangrene) started appearing on patient's right big toe, then from 28th Mangsir right foot and all 5 toes turned black; next doctor said this is because of nerves jam and needs to cut leg; hepadin drug was started; on 2nd Poush D said no need to cut leg and leg will be normal after 6 weeks and went out saying same even when he revisited on 7th Poush, the last time to patient.

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[123] *Dr. Bulanda Thapa v. Shushma Thapa*, NKP 2074 V 5 D.N. 9814

Dr Ashok Bajracharya's team had to conduct leg removal surgery two times on 2062/09/29 (below knee) and 2062/10/16 (above knee) to prevent further gangrene development. DCC awarded compensation of Rs 9,20,000/- along with its market rate interest from D on 2066/02/14. D appealed to high court that upheld the compensation amount by quashing interest on ground of no claim of interest by petitioner and no legal provision to award interest. D appealed to Supreme Court that upheld decision of DCC to awards the amount Rs 9,20,000/- only from D but no interest. Supreme court found inability of plaintiff to establish onus regarding how the hospital was negligent.

Supreme court even took into judicial notice that no action was taken by previous court regarding: (i) DCC had seeked expert opinion through Nepal medical council but the concerned doctor had replied back to NMC showing inability to give opinion in this issue. (ii) Plaintiff had claimed compensation against both- doctor Thapa and Bir hospital but DCC awarded compensation only from doctor and spoke nothing about hospital.

Precedents established in the case can be put in following words:

- Patients are treating doctors as god but doctors are presenting themselves as businessman. This conflict is the cause of tension and reason that has severely affected our health care system. Medical service is not a business. It is not a profession where partnership or unfair agreement (*saudabaji*) needs to be done.
- The quality of health service our health care system has been been delivering has been seriously affected by behaviors like- failure of doctors to adequately counsel patients,

forcing patients to visit self- invested labs for repeated medical tests, starting surgery without performing adequate diagnosis, prescribing antibiotics immediately even when not necessary, creating psychological fear in the mind of patient showing need of urgent surgery to emotionally blackmail patient for gaining undue personal benefit and so on.

- Aggrieved patient consumer has right to obtain compensation against the negligent loss inflicted by wrong medical service or negligent behavior issued by doctor. Court can not underestimate the fact of negative attitude of public developed towards overall health care system due to wrong and negligent treatment provided by few doctors. The purpose of establishment of consumer protection Act is also to protect patient consumers against negligent or wrong treatment by medical doctor. It is justifiable for affected patient to seek compensation against negligent medical service provider as per consumer law.
- Patient consumers have been suffering from the trend of doctors to hesitate giving fair expert opinion report to court against other negligent doctors being biased towards patient for protecting doctors as members of their professional fraternity. This mal-culture among doctors has increased impunity to negligent doctors and it will erode our medical service system. This serious pressure on patient needs to be seriously considered by court with judicial mind in order to prevent irrecoverable financial and health loss inflicted to patient.

The judgment has beautifully highlighted numerous wrong practices have been eroding the quality of our health care system. These behaviors can broadly be categorized into two types of unwanted activities- medical negligence and medical malpractices. Numerous behaviors are criminalized in scattered statutes in Nepal till date. We are still awaiting a comprehensive law entitled- Medical Negligence and Malpractices (Control) Act that would define medical negligence, distinguish simple negligence and criminal negligence, criminalize gross negligence, define various unhealthy behaviors of medical sector as medical malpractices, criminalize medical malpractices and provide a range of punishment for each.

The Supreme Court of India has emphasized on need of rendering immediate medical aid to injured persons to preserve life. Both state as well as doctors are obliged in this regard.[124] Further the court has also held the government hospitals run by the State and the medical officer employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of patient right to life guaranteed by the constitution.[125] Thus, denial medical service in case of emergency will be termed as medical negligence from the hospital side.

Medical patient are considered as service consumer having right to receive standard service facility or treatment from both the hospital and the medical practitioner under Consumer of the state. Establishment of causation of medical negligence is harder one. Failure of any surgery, no recovery of patient or even death during the operation is not medical negligence. When a doctor undertakes to diagnose his patient he cannot provide guarantee of saving life or full recovery from the disease. Recovery depends on numerous factors. Therefore, medical negligence should be viewed differently. Courts always see it as failure to meet standard of duty of care not as failure to save life. Medical negligence could be seen in following cases:

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[124] *Pt. Paramananda Katara vs. Union of India &Ors., 1989 (4) SCC 286.*

[125] *Paschim Bangal Khet Mazdor Samitii v. State of West Bangal, AIR 1966 SC2426*

- Prescribing medicine without completing due process of diagnosis,
- Prescribing more dose of drugs than needed in treatment,
- Administering drugs which is not to be administered for treatment purpose,
- Negligent practice in operation and loss or damage is caused to the patient,
- Pharmacist providing wrong medicine than prescribed by medical practitioner.

Even in resolving civil disputes at court, forensic medicine and autopsy examination is helpful. In suspicious and alleged case of death due to medical negligence, autopsy examination of deceased patient can discover whether death was due to negligence of: (a) anesthetist (e.g.- over dose leading to death or underdose leading to early gain of consciousness during surgery leading to death due to shock), (b) doctor (e.g.-prescribing chemo therapy to patient whose report shows he is infected with tuberculosis), (c) surgeon (e.g.- cutting intestines while cesarean operation of a pregnant women), (d) nurse (e.g.- death of patient due to injecting intravenous injection that was meant to be intramuscular or due to air embolism), (e) pharmacist (e.g.- dispensing wrong drugs or date expired drug), (f) lab technician (issuing wrong blood grouped blood to patient awaiting blood transfusion in hospital), (g) hospital management (e.g.- hospital acquired infection in post operative ward of patient due to improper management of medical waste management and lack of hygiene or delay in making arrangement for quick oxygen supply facility to emergency patient), (h) drug manufacturer or pharmasuitical industry (e.g.- manufacture of substandard drugs and medical equipments violating Good manufacturing Products terms).

It is a shame, Nepalese law still does not require negligently killed patient in hospital bed, to be forwarded for mandatory autopsy examination with purpose to identify exact cause, manner and time of death and verify, whether treatment involved negligence. Till date, we are blindly relying on and trusting oral announcement of commercially established private hospitals' words regarding cause of patient's death in their bed.

Usually the remedy for medical negligence is under civil liability against negligent health care provider where patient suffering loss claims compensation under Consumer Protection Act, 2075 B.S. Only in rare cases of maliciously intended harm or serious disregard to life of patient, negligent physician/nurse/surgeon may get prosecuted for criminal negligence under section 231 and section 232 of *Muluki* Criminal Code, 2074 B.S.

Simply because patient died in hospital or simply because treatment could not be successful is not an indicator of medical negligence so long as doctor applied reasonable care and effort towards saving life and making treatment success.

In *Nesar Ahamad Miya* case,[126] fact of the case shows patient victim- Rajiya Khatun, 19 years was who was admitted to Prithvi Chand hospital, Parashi on 2064/03/09 10:30 PM where she delivered baby same night on 11:53 PM. The next day day morning of 10th Ashar 6:00AM, defendant doctor examined her and found laceration on Vaginal Mucosa causing hematoma and for stopping continuous bleeding, he performed Hematoma Drain and Vaginal Mucosa Stitch but bleeding did not stopped and patient's condition went deteriorating while Dr. examined her at 4:00 PM same day despite giving her painkiller and antiobiotics. Dr. opined patient's condition is stable and her sample has been forwarded to conduct haemoglobin and blood group test. Suddenly, she went unconscious. Dr. discharged her immediately after 25 minutes of her consciousness regain with referral to higher centre- Lumbini Zonal Hospital, Butwal where

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[126] *Nesar Ahamad Miya* v. *Dr. Pramod Poudel et.al.*; NKP 2075, V 7 DB DN 10061

where she could not get treatment and was taken same day night to Universal Medical college, Bhairahawa where she could not get treatment and taken to Star Hospital, Gorakhpur India and admitted on 11th where she died on 12th Ashar 7:00 PM. District Compensation committee awarded compensation of Rs 45,000/- to victim from Prithvi Chand hospital. Plaintiff (father in law of deceased patient) appealed demanding modified compensation of Rs12,19,600/-. High court denied compensating on ground of inability o establish onus showing inability of plaintiff to establish what standard of service needed to be provided and what standard was indeed given. Plaintiff appealed to Supreme Court demanding same. Supreme court upheld decision of Compensation Committee but denied to award demanded increased amount of compensation on ground of inability to identify extent of negligence by other succeeding hospitals and plaintiff also had not claimed negligence from these succeeding hospitals.

Precedent laid in the case has established:

- Health is one of the services received by consumers. Health services must be qualitative from all aspects whether it is provided by government or non government or private institution or person. In absence of quality health service delivery, person's numerous rights get ineffective, frustrated, and meaningless such as right to health, education, employment, income generation, and right to dignified life.
- *Locus standi* to complaint against negligent service provider lies on aggrieved party or consumer institution or family members of patient in case of inability to complaint by patient. Narrow interpretation that only consumer institution can file complain is irrational and unjustifiable.
- While determining negligence by court, it should be seen

that there exist duty of care on doctor or health institution, such duty was violated, and such violation caused some loss to patient. Direct causal relation needs to be established between breach of duty and loss to patient for negligence claim to be established.

- A doctor should not be blamed for medical negligence so long as s/he continues treating patient with due care. But if a doctor treats patient regarding disease to treat which he is not specialized or authorized to deliver treatment, or has committed inexcusable errors and negligence, such instances must not be covered.
- Its is direct liability of doctor to provide treatment to patient undertaken by such doctor. It is vicarious liability of the hospital or health institution to ensure treatment is delivered to such patient through the doctor.
- In medical negligence dispute, courts mainly need to see nexus between cause and effect. Besides this, courts also need to notice whether due obedience to duty of care has been performed by doctor or not and other matters such as what does fact of the case tell? How is the situation of preponderance of evidence etc. also need to be cared.
- Health care professionals need to take special care regarding rights of patient to obtain true information and right to self-determination in making choice whether to accept certain service or not.
- Right against medical negligence is interconnected with right of crime victims to participate in investigation and right to obtain justice alone with compensation (Article 21 of Constitution). Prior to determining whether negligence had really occurred in a dispute, court should take into notice these broad considerations, and identify whether this is a subject matter of civil liability or not.

Negligence happens when duty to take care is violated.

- Negligence may create two sorts of liabilities depending on situation- civil liability and criminal liability. Under civil liability, negligent person or institution has duty to compensate patient victim either under consumer protection law or under tort. Under criminal liability, negligent person could be imprisoned in addition to imposition of compensation as this involves high degree of negligence or gross negligence such as- (a) treating by unauthorized person, (b) unexpected activity done by negligent doctor that is not expected or done by other reasonable professional doctor such as- surgery on wrong site, leaving foreign bodies like scissors or gauze inside body.

Supreme court in *Nesar Ahmad Miya* case has interpreted treatment by unqualified person ('*yogyata nabhayeko manisle upachar gareko*') falls under criminal negligence. This interpretation is slightly inconsistent with globally accepted prevailing jurisprudence on medical negligence. This interpretation is half truth. If a person being medical doctor treats patient for disease that does not fall under the doctor's field of specialization, it may be civil negligence provided that the condition of patient is not severe. If the patient's condition is emergency demanding specialized medical treatment and if there was possibility of treatment by specialized doctor yet the unspecialized doctor provides treatment and fails to save life of patient, this could be prosecuted for gross negligence or criminal medical negligence. Had the honorable court highlighted this scenario in its interpretation, the precedent would have been comprehensive.

Where, a non medical person (quack) treats patient, it is intentional crime. The author emphasizes- The incident of 'treating by unqualified person' is not criminal negligence, this should be seen as intentional offence related to medical treatment. It is not just a category of negligence such as simple negligence or gross negligence; it is much grievous in nature with wider social impact. Giving treatment by licensed health care provider in grossly negligent manner with serious disregard and disrespect to the life of patient indeed falls under criminal negligence. Taking initiation to treat some patient by a person unauthorized to do so is purely intentional crime and not just mere negligent state of mind. The state of mind and *mens rea* that exist in 'intentional and deliberate state of mind' differs from the state of mind that exist in 'high degree or gross negligence'. This thin margin that differentiates between criminal negligence and intention crime in medical treatment sector is still awaiting judicial interpretation in our legal system.

Crime of treatment by quakes (unauthorized persons or duplicate doctors) is to be investigated, prosecuted and adjudicated as per Section 230 of *Muluki* Criminal Code, 2074 B.S.

What exactly happens in 'Gross medical negligence' instances has been comprehensively discussed by Indian Supreme court in numerous cases. Nepalese judiciary has yet to explain whether criminal proceedings can be initiated while civil proceedings is claimed against negligent doctor. Indian judiciary clearly points both civil proceedings as well as criminal trial may go side by side. In *Jagdish* case,[127]

Supreme Court observed that even though treatment provided by child specialist doctor (running a private hospital) based on wrong diagnosis leading to death has already been held negligent, it is within the jurisdiction of trial court whether to convict even under section 200 of Cr PC. In *Dr Brijesh Kumar* case,[128] it was observed that criminal proceedings launched by complainant on the same cause of action cannot bar to the civil proceedings of the complaint under the CP Act.

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[127] *Jagdish* v. *State of A.P.*, (2009) I CPJ 18 (SC).

Every rights of accused in relation to criminal justice needs to be provided prior to convicting a suspect. In *Mohanan* case,[129] it was held that criminal negligence could be ascertained only by scanning the material and the expert evidence and the complainant should be given an opportunity to present his case before the magistrate as culpability could be established only on the proper analysis of the expert evidence that may be adduced by the complainant.

In a landmark *Jacob Mathew* case,[130] Indian Supreme Court held that for negligence to amount a criminal offence, element of *mens rea* must be shown to exist. It is recklessness that constitutes the *mens rea* in criminal negligence. The court further held that the jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. Generally speaking, it is the amount of damages incurred which is determinative of the extent of liability in tort, but in criminal law it is not the amount of damages but the amount and degree of negligence that is determinative of liability. To fasten liability in criminal law, the degree of negligence has to be higher than that of negligence enough to fasten liability for damages in civil law i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis of prosecution. Also the court in *Jacob Mathew* case has issued Guidelines for filing private complaint against doctors, procedure for arrest of doctor and applicability of *res ipsa loquitor* along with warning that a doctor cannot be prosecuted for simple lack of care and error of judgment or accident during treatment. In *Suresh Gupta* case,[131] it was observed that the act complained against a doctor must show negligence or rashness of such a high degree as to indicate a mental state which can be described as totally apathetic towards the patient. Such gross negligence alone is punishable.

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[128] *Dr. Brijesh Kumar Mishra and another* v. *State Consumer Disputes Redressal Commission, U.P. Lucknow and another*, 209 CTJ18 (All).

[129] *Mohanan* v. *Prabha G.Nair & Anr*, I (2004) CPJ 21 (SC).

[130] *Jacob Mathew* v. *State of Punjab*, AIR 2006 SC 3180.

It is to be noted that simply providing treat expenses by doctor and hospital in case of proven medical negligence is not compensation. The purpose of compensation is to restore the loss as an excuse from negligent health care provider even though the value of loss or life cannot be restored at any cost by the negligent health care provider. Compensation amount has to be meaningful, exemplary, and adequate,[132] not just reasonable or just ritual or just like showing teeth of elephant. It should calculate loss caused on productivity of patient in case of health deterioration, financial impact on dependent family members in case of death of earning member till average life expectancy of the citizen, future treatment expenses, mental stress, and deterrence to other health care providers as a strategy to prevent medical negligence in future and so on.

Under civil laws, at a point where the Consumer Protection Act ends, the law of torts takes over and protects the interests of patients. This applies even if medical professionals provide free services.[133]

There is a need to enact a comprehensive and self contained statute- Medical Negligence and Malpractice (Control) Act" for addressing all aspects of Medical Negligence and medical malpractice. The statute should regulate recently emerged issues in health care legal sector such as euthanasia, surrogacy, informed consent, mental health, duties of doctors, nurses, lab technicians, paramedics in addition to bringing the relevant provisions scattered in various laws such as *Muluki* Civil Code, 2074 B.S., *Muluki* Criminal Code, 2075 B.S., Public Health Service Act, 2075 B.S. and so on. Our health care system needs to be founded on the Theory of Informed Consent. It is advisable advisable for government to introduce National Standard Treatment Guidelines which will bring uniformity and transparency in manner of treatment and prescription of drugs throughout the country.

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[131] *Suresh Gupta* v. *Govt. of NCT of Delhi*, 2004 (6) SCC 422.

[132] Supra note 3.

[133] Talha Abdul Rahman, *"Medical negligence and doctors' liability"*, *Indian J Med Ethics*, Apr-Jun;2(2) (2005). (Source: http://www. issuesinmedicalethics.org/ 132hl060.html)

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